



Healthcare Analytics in Navy Medicine

Perspectives and Methods for Decision-Making

FOCUS ON DOD AND VA INTERAGENCY COLLABORATION

Improving Beneficiary Care Through DoD-VA Healthcare Resource Sharing Program

The Department of Defense (DoD) and Veterans Administration (VA) have collaborated on hundreds of initiatives over the years that aim to improve the coordination and sharing of efforts between the Defense Health Agency (DHA) and Veterans Health Administration (VHA). This article highlights and provides background on two key DoD and VA collaborations involving Navy Medicine. The following was constructed from an interview with Ms. Gilda Collazo, the DoD-VA Program Manager for BUMED.

Background

The Department of Defense (DoD) and Veterans Administration (VA) have more than 30 years of health care resource sharing experience, which was first mandated in the late 1980s per the “*The Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act*”.¹ This legislation was prompted due to the administrative and regulatory challenges that DoD and VA facilities located close to each other faced when they tried to partner and share resources. The new legislation provided each Department with specific (and separate) authority to share healthcare resources. In 2003 additional legislation was passed where Congress directed the establishment of a Joint Executive Committee to oversee, at a strategic level, collaboration between both departments to work together to address and reduce barriers. Today there are more than 200 sharing agreements and ten joint ventures between DoD (Military Treatment Facilities) and VHA (VA Medical Centers) facilities across the U.S.

For example, DoD-VA healthcare resource sharing initiatives encompass a wide range of services, such as education and training, medical/surgical, traumatic brain injury, blind rehabilitation, spinal cord injury, gastroenterology, obstetrics/gynecology, mental health, pharmacy, pathology, physical therapy, and physical examinations. These efforts minimize duplication and underuse of healthcare resources, promoting cost-effective use of federal healthcare resources and benefiting both Departments’ beneficiaries. For years, DoD-VA sharing sites have been increasing the volume of business as well as moving beyond the early health services buyer/seller relationships to increasingly more integrated and consolidated operations.

Ongoing DoD-VA interagency collaborations seek to improve the joint coordination and sharing of efforts between and within the two agencies and align with the DoD-VA Joint Strategic Plan (JSP). The bottom line: “reduce cost, increase access, and improve quality.” The Lovell Federal Healthcare Center (FHCC) and Advanced Payment Initiative are recent examples of DoD-VA collaboration initiatives involving Navy Medicine, and these efforts are highlighted below.

Captain James A Lovell Federal Healthcare Center (FHCC)

While previous collaboration efforts in the North Chicago, Illinois area are seen as the “genesis” for the DoD-VA resource sharing laws in the 1980s, it was

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¹ Public Law 97-174 (and subsequent program authority from Public Law 107-314; Title 38, Section 8111; Title 10, Section 1104; DoD Instruction 6010.23, 23 Jan 2012, Department of Defense and Department of Veterans Affairs Health Care Resource Sharing Program (being updated 7/11)). For more information, please visit DHA’s webpage, or contact the DoD VA Program Coordination Office (DVPCO) which is part of the Defense Health Agency (DHA).



in 2010 that the first joint, combined DoD-VA facility was established. As authorized by the National Defense Authorization Act (NDAA) 2010, VHA and Navy facilities in North Chicago expanded their efforts to share health care resources to more fully integrate their medical facilities as part of a 5-year demonstration project.² The Lovell FHCC aimed to meet the health care missions of both departments by integrating services previously provided by the former North Chicago VA Medical Center and the Naval Health Clinic (NHC) Great Lakes into a single facility. The Secretaries of VA, DoD, and the Navy entered an Executive Agreement (EA), or a single line of authority and budget, which defined their roles in operating and overseeing the FHCC and established other requirements.

The demonstration aimed to test a national model for the joint delivery of health care that would be more accessible and less expensive than operating two federal medical centers serving both agencies' beneficiaries in the same area, and its effectiveness was to inform decision makers of potential replication and scaling up of this model of care. The Lovell FHCC was evaluated in a July 2016 Report to Congress, and DoD and VA recommended that the FHCC demonstration continue and the facility continue operating as an integrated facility. However, GAO reports issued in 2011, 2012, and 2016 found that, although the departments had made significant implementation progress, there were still difficulties with the integration in areas such as IT and workforce planning.

One of the most significant challenges the Lovell FHCC faced were issues with IM/IT electronic health record (EHR) system capabilities. The incompatibility of the DoD and VA EHR systems required financial investment of over \$100 million to build capabilities to support data interoperability and integration initiatives. The IM/IT model was both costly and complex, in terms of implementation, maintenance, and data transaction structure. According to Gilda Collazo, the DoD-VA Program Manager for BUMED, there have been challenges.

"It has had its major challenges, since we were bringing two organizations together (for example, organizational cultural differences),³ but the biggest

challenges had to do with the electronic health record (EHR) and IM/IT data sharing. DoD wanted to keep their EHR, and VA wanted to use theirs. Because we weren't going to use one over the other, we had to build bridges between the two systems to move key orders and other clinical transactions and data back and forth. That made it problematic when it was time to measure how successful this joint effort has been. It was very difficult to find consistent metrics, since data was collected differently in each organization. It has taken a heavy lift to find a way to mine and process the data so we can get some information regarding performance of the facility. It was more challenging from the DoD side, that's where we didn't have the kinds of performance measures that other facilities had readily available (e.g., HEDIS measures, ER utilization). They had major barriers to making this happen. A lot of the issues are going to be resolved once we move to the same EHR."

There were significant financial IM/IT investments at the Lovell FHCC, justified in part by the intent to export those unique EHR transactional capabilities to other DoD-VA sharing sites. However, there have been many barriers to making these capabilities operational. "While work-arounds have been devised at most sharing sites, they are all uniformly labor intensive and often incomplete or inadequate to resolve the identified barriers."

Advanced Payment Initiative

In response to challenges identified in another GAO Report⁴ with regards to DoD and VA billing practices, DoD and VA leadership have also worked to improve interagency billing and reimbursement. In 2014, the Office of Management and Budget (OMB) directed the two agencies to collaboratively devise and agree to a simplified reimbursable billing solution.

In December 2016, a supplement to the DoD-VA National Resource Sharing Guidelines Memorandum of Understanding (MOU) was signed, which committed the Departments to implement a national prospective payment system not later than January 2018 for VA care rendered in DoD MTFs. The intent is to provide a uniform set of instructions supporting VA/DoD resource sharing and establish an advanced payment process, which will

² The NDAA 2010 also required DoD and VA to submit a report of their evaluation of the demonstration and their recommendation as to whether it should continue operating as a fully integrated facility after 5 years.

³ Culture differences were significant for a "joint" facility, and there is uncertainty whether these can be fully resolved without one agency in a position of complete control.

⁴ GAO, VA AND DOD HEALTH CARE - Department-Level Actions Needed to Assess Collaboration Performance, Address Barriers, and Identify Opportunities, GAO 12-992.



supersede local, direct sharing agreements related to billing and payment.

VHA will make a quarterly corporate-level advance payment to DoD against all local sharing agreements within 15 days of the start of the quarter based on the annualized baseline estimate, and payment and workload adjustments will be made following quarterly payments. At the end of the fiscal year, DHA and VHA will meet and confer to determine the final payment reconciliation amount. The new rate structure for VA to DoD referred care is based on Centers for Medicare & Medicaid Services (CMS) guidelines and rates for reimbursement less 20 percent.

This advanced payment initiative aims to: improve the speed and timeliness of payment, simplify processes, and reduce the administrative burden and costs. In addition, this new methodology will result in increased visibility at the corporate-level of local facilities' work processes, and there will be increased requirement for greater fidelity at local levels to ensure proper registration of VA patients in DoD EHR, consistent and clear language in VA authorizations, and care provided within scope of original VA authorization.

However, implementation of the advanced payment initiative has had some roadblocks. The goal was to roll it out as a pilot at three MTFs in the Summer of 2017; however, it has only become operational at one site (Pensacola) as of October 2017. Thus far, the data that have been processed are promising, and the aim will be to finish the cycle and then roll this out to some Air Force and Army sites.

“On the surface, the advanced payment methodology might sound simple, but VA and DoD data and processes are so different and challenging. It will be significant achievement if we can move to this model, as it has the potential to save hundreds of dollars in terms of manhours” Ms. Collazo.

Summary

Ms. Collazo notes that DoD-VA interoperability issues challenge not only the Lovell FHCC but also other collaboration efforts from a broader perspective, such that “limitations of IM/IT EHR transactional capabilities at these advanced sharing sites are the number one barrier to increased collaboration and consolidation of services.” Ongoing efforts to address these challenges are prioritizing both transactional activities and operational capabilities. As efforts continue to advance interoperability and

further the possibility of a single EHR for use across both agencies, it may be possible to look across all facilities in specific regions to make sure DoD and VA facilities can work together as one system.

Information for this article was constructed by Ms. Sarah Irie (Kennell and Associates) from an interview with Ms. Gilda Collazo, the DoD-VA Program Manager for BUMED.

SKILLS AND METHODS

– DOD-VA ADVANCED PAYMENT PROGRAM

The DoD-VA Advanced Payment Pilot was launched in the beginning of FY 2018. The aim of the Advanced Payment Program is to improve the speed and timeliness of payment, simplify processes, and reduce the administrative burden and costs when VA patients are seen at DoD facilities. This article will describe the data flow and reimbursement methodology for VA pre-approved care (e.g., VA consults) being applied under the DoD-VA Advanced Payment Program. While a similar data exchange and approval process will be applied for emergency care through the use of hospital notifications under the DoD-VA Advanced Payment program, it will not be covered in this article.

Data Flow Process

The flow of data starts with the VA, where consults for VA patients are entered into the new consult template in the Computerized Patient Record System (CPRS). The consults are sent to the nearby DoD facility, where the VA patient has been pre-approved for care. VA's adoption of the new consult template is key in the DoD-VA Advanced Payment process as it contains standardized fields with specified valid values to which logic and mappings can be applied, so that VA Consults can be mapped to DoD data.

Data from CPRS are collected and processed centrally by the VA and sent as a monthly extract to the MHS Data Repository (MDR), where VA consults are matched to DoD encounter data. Complete matches are sent back to the VA as claims for reimbursement and incomplete matches (e.g., “exceptions”) are sent back to the MTF and VA facilities for reconciliation in an Exception Report.

Methodology for Matching VA Consults to DoD Data

VA consults are matched by person, date, and type of



care. Each VA consult contains a patient's Social Security Number (SSN) and date of birth (DOB), both of which are used to identify the patient in the DoD Encounter Data. Furthermore, the VA consult contains a date window for when the patient can be seen and a VA consult service name, which is a standardized field relating the type of care that has been pre-approved for that patient. The VA consult service name ranges from 'Inpatient Care' to 'Urology' to 'Radiology MRI', so it covers the spectrum from inpatient care to outpatient consults to direct radiology or laboratory encounters. For non-inpatient care, the VA consult service name field is mapped to a MEPRS 3 Code or Provider HIPAA Taxonomy mapping to determine if the care provided was appropriate for the type of consult sent and within the date window indicated. For inpatient care, an inpatient specialty field on the consult is mapped to the Major Diagnostic Category (MDC) or Provider HIPAA Taxonomy on the DoD Standard Inpatient Data Record (SIDR) to determine if care was appropriate. If DoD encounter data successfully matched to a VA consult by person (e.g., SSN, DOB), date (e.g., encounter date was within the consult window), and type of care (e.g., MEPRS 3 Code/MDC or Provider HIPAA Taxonomy mapped to the appropriate VA consult service/inpatient specialty field), then a claim is created and sent to the VA.

One of the advantages of the DoD-VA Advanced Payment program is that it alleviates the local billing burden across MTFs who are seeing VA patients under DoD-VA resource sharing. The focus locally will shift from producing claims to reconciling the Exception Report. Initially, substantial local efforts will have to go to resolving consults and DoD care on the Exception Report, as the VA is standing up a new process with a new consult template, and MTFs are still seeing patients under old consults to which DoD care cannot be mapped. In the latter case, all care for VA patients that occurred under an old VA consult will show up on the Exception Report as K61 care with no VA Consult. This transitional care local MTFs will have to continue billing under the old local sharing agreements as only care done under the new VA consults can be billed under the Advanced Payment program.

Claim Types

The VA consult can cover any type of care (e.g., inpatient, outpatient, laboratory or radiology), so what can be billed centrally under the DoD-VA Advanced Payment Program?

Essentially, billing can include all inpatient care, same day surgeries, ambulatory care (and any related lab and rad), direct radiology, laboratory, and pathology, as well as any associated pharmacy (e.g., discharging medication after an inpatient stay). Durable Medical Equipment (DME) is not captured well centrally, so it will continue to be billed locally. The agreed upon reimbursement rate is Medicare minus 20 percent for most care except for Pharmacy, where the first fourteen days of the medication are covered and billed by the ingredient cost with an agreed upon dispensing fee.

Depending on the episode of care, one or more claims will be generated from the encounter data. If the episode of care is an inpatient stay, then TRICARE MS-DRGs will be translated to Medicare MS-DRG and priced according to the MS-DRG, facility, length of stay and inpatient institutional claims will be created. Inpatient professional services (e.g., A CAPERs associated with the inpatient stay) will be billed under professional claims, so it is vital for MTF providers to code their workload or the 'A CAPERs' or the MTF will be reimbursed for those services. Under this program, only coded encounter data will be processed and incomplete or inferred encounter data will never be billed. If care is not coded in a timely manner, then the cost of care provided to VA patients cannot be recouped.

Pilot to MHS-Wide Adoption

The DoD-VA Advanced Payment is currently operating as a Pilot program. However, it is currently on-track to roll out to all Army, Navy, Air Force, and National Capital Region (NCR) MTFs located in the continental U.S., Alaska, Hawaii, and Guam by the end of FY 2018.

DATA AND INFORMATION SYSTEMS

– DOD-VA DATA COLLABORATIONS

Nearly one million beneficiaries utilize both the Military Health System (MHS) and the Veterans Health Administration (VHA) each year. Since so many people are eligible within both systems simultaneously, and since hundreds of thousands of Service Members transition from the DoD to the VA each year, sharing data between the DoD and the VA is crucially important. There are many barriers to this interoperability, but the scope of data sharing has increased in recent years.



Transactional Data

The MHS's Pharmacy Data Transaction Service (PDTs) collects pharmaceutical data for DoD beneficiaries regardless of where the prescriptions are filled. This simplifies claims processing, but also improves patient safety by reducing the risk of adverse drug interactions. PDTs collects data from Military Treatment Facilities (MTFs), retail pharmacies, the TRICARE Mail Order Program (TMOP), and, since 2006, VA Medical Centers (VAMCs). In FY16, more than 13 million prescriptions filled at over 200 VA pharmacies were captured in PDTs.

The Health Artifact and Image Management Solution (HAIMS) was deployed in 2014 to allow for sharing of medical artifacts and images between DoD and VA. These include radiographs, photographs, EKGs, and more. Instead of having to exchange paper records, or even repeating tests on the same patient, HAIMS allows providers in both systems to view the results of a given test. HAIMS also creates a Service Treatment Record (STR) when service members separate from the DoD and makes it available to the Veterans Benefits Administration (VBA).

Most VAMCs are also TRICARE network providers, meaning they can provide care to MHS beneficiaries. VAMCs then bill TRICARE just like civilian providers would. In the MHS Data Repository (MDR) and MHS Mart (M2), these claims will show up in the TEDI and TEDNI files. Looking up the provider's name using a reference file like the National Provider Index (NPI) Directory or the Purchased Care Providers file should reveal them as VAMCs. There are also cases where MTF providers work within a VAMC in what is known as external resource sharing. Similar to civilian resource sharing, any institutional records will show up in the TEDI or TEDNI, while the professional records show up as a CAPER. On the CAPER, they should have 'Tmt DMIS ID Military Service' = 1, 2, 3, or 6 for resource sharing agreements from the Army, Navy, Air Force, and National Capital Region (NCR), respectively.

With the VA Choice Act, the VA has been encouraged to refer their patients more and more to MTFs. If a VAMC has a backlog of patients, and a nearby MTF has capacity to spare, this can be a win-win for both systems. The new DoD-VA Interagency Billing Program aims to streamline this process. Referrals are sent directly from the VA to the MTF, and the patient is authorized to receive care.

In the MDR those referrals are matched to records of the care provided from the Composite Health Care System (CHCS) and bills are generated to send back to the VA. The centralized nature of the billing process will ease the burden on local MTF staffs creating bills, and allow for easier analysis of how much care is being provided and how much money is changing hands.

Operational and Research Analyses

Another new collaboration between the two systems is the DoD and VA Infrastructure for Clinical Intelligence (DaVINCI) project. This project aims to increase data integration, simplify the governance process for operational and research analyses, and provide a technical solution for access and use of the data. Simply, the goal is to combine data that currently resides on separate systems and make it possible to analyze the complete health history of veterans from accession in the DoD through their transition to the VA. The project is still being rolled out, but already billions of rows of data have been exchanged bidirectionally between DoD and VA. In order to facilitate analysis between the two data sets, the data will be transformed into the Observational Medical Outcomes Partnership (OMOP) Common Data Model (CDM). This data model allows for standardized analytical tools to be used on disparate data sources, and allows users who are not experts in both DoD and VA data to complete their analyses.

One study that has been completed under the DaVINCI umbrella looked at the rate of fulfillment for mental health referrals on the Post-Deployment Health Reassessment (PDHRA). Since many guard and reserve service members filling out a PDHRA are nearing the end of their Transitional Assistance Management Program (TAMP) benefit, there is a high likelihood of those beneficiaries receiving that care in both the MHS and VHA. This project was able to show those fulfillment rates, and found that Active Duty Service Members had 97 percent of their fulfillments in the MHS, while guard and reserve members had 71 percent of their fulfillments in the VHA.

The Lovell Federal Health Care Center is another example of the need for data integration between DoD and VA. This facility is run jointly by the DoD and the VA, and data collection occurs in both MHS and VHA data systems. Inpatient care and emergency department care are collected in the Veterans Information Systems and Technology Architecture (VistA), while laboratory and



radiology are collected in CHCS. Two separate mental health clinics are run by each agency, with data collected in the two data systems. This disaggregation of data made it impossible for leadership at Lovell to understand the healthcare they were providing, and for the two agencies to reconcile the cost of providing that care. Currently, data from VistA is sent to the MDR, where it is combined with data from CHCS to facilitate the financial reconciliation each quarter. In addition, metrics like ER utilization, readmission rates, provider productivity, and mental health follow-up are calculated and provided to leadership at Lovell. In the future, with the help of the DaVINCI project, this process may become simplified.

Summary

The MHS and VHA are inextricably linked, and increasing the capability of sharing data has long been a goal of the two systems. Much progress has been made over the years, but there is still a long way to go before the systems will be truly interoperable. Recent and upcoming projects like the Interagency Billing Program and DaVINCI should help strengthen the link between the DoD and VA and help serve beneficiaries, providers, and analysts alike.

NEW KNOWLEDGE

– ANALYTIC AND STATISTICAL RESOURCES

This online resource provides detailed statistics and data on the Veterans population and programs.

National Center for Veterans Analysis and Statistics

The National Center for Veterans Analysis and Statistics (VANCVAS) develops statistical analyses and reports on a broad range of topics, operates VA's data and statistics Web portal to disseminate Veteran data and statistics, and develops estimates and projections on Veteran populations.

Additionally, VANCVAS leads interagency data-sharing collaborations with other Federal agencies, and conducts survey analyses and research including future iterations of the National Survey of Veterans.

VANCVAS also leads the effort to implement corporate data governance and corporate data management in VA, and implements enterprise business intelligence tools and processes to support analysis and planning activities in VA.

A full range of resources are available including reports, surveys, and statistics on issues related to the Veteran population, service utilization, and expenditures.

VANCVAS resources can be viewed at <https://www.va.gov/vetdata/>.

TIPS AND TRICKS

– OPENING A WEBI SESSION IN BCS 4.2

The upgrade to the 'new M2' came with a few changes to the M2 Portal. Infoview is now BI Launch Pad, and launching a new WEBI or WEBI-Rich Client (WEBI-RC) session is no longer done with 'Document List' and 'New'. This article will discuss how to open a new WEBI session in BCS 4.2.

Accessing BCS 4.2

The URL for the new M2 (BCS 4.2) is <https://dha-bcs.csd.disa.mil>. After inputting a CAC PIN and agreeing to the HIPAA and Privacy Act Warnings, the user gains access to the new M2 portal called 'BI Launchpad' (see Figure 1). The default page is the 'Documents' tab which shows the user's space on the repository (e.g., My Favorites, Inbox). The Public Folders are also accessed through the 'Documents' tab on the bottom right corner under 'Folders'. The pathway of the Public Folders mirrors the old M2. The 'Home' tab is the second tab in BI Launchpad and it displays the most recently opened reports, uploaded Excel External Data Providers, and most recently built reports, but each of these can be customized. At the top of BI Launchpad, the user's name is displayed without the PII EDIPN; however, the EDIPN is still displayed in the 'Created By' column, so users taking screenshots of M2 still need to exercise caution.

On the top right of the BI Launchpad are 'Preferences', which as in the old M2, enable users to toggle between WEBI and WEBI-RC, where WEBI is completely web based while WEBI-RC requires an installation component, which can be downloaded from the 'Web Intelligence' page in 'Preferences'. The functionality of WEBI has increased in the new release. WEBI can now handle External Data Providers as long as the files are uploaded into the repository and do not sit on a user's PC. However, WEBI being web based can still time out, so it is not as stable as WEBI-RC and users still cannot



save reports to their PC (just download Excel files). To select WEBI, a user clicks on 'Preferences' and 'Web Intelligence' and then chooses HTML (WEBI) for viewing and modifying mode (Figure 2) .

Figure 1. BI Launchpad

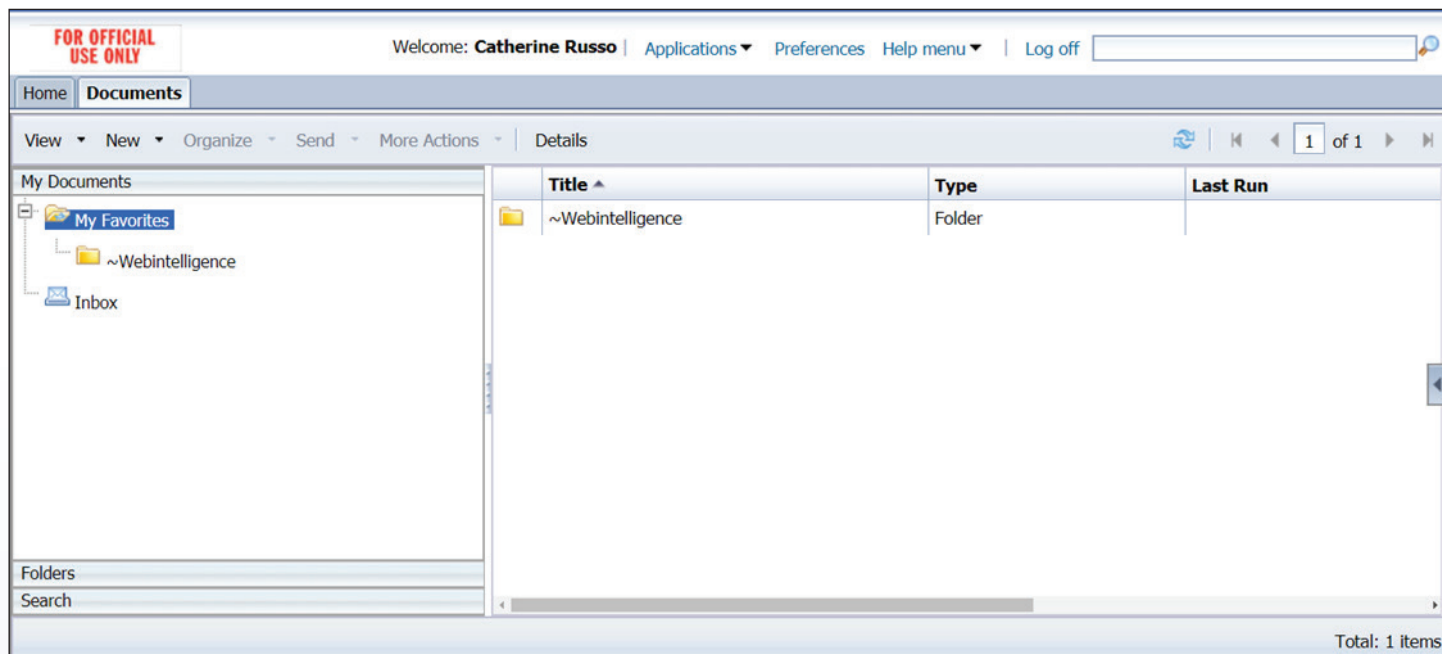
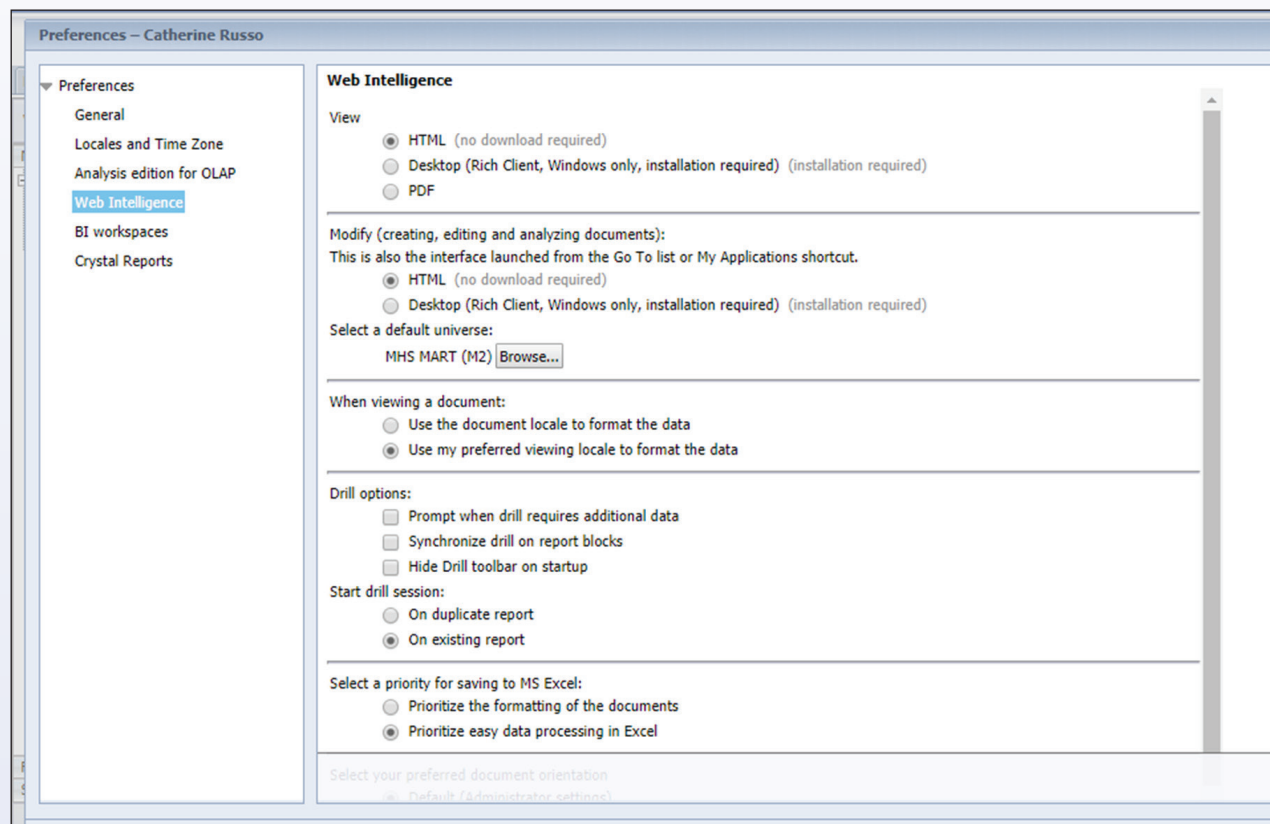


Figure 2. Web Intelligence Preferences





Launching a WEBI Session

To launch a WEBI session, select 'Applications' and 'Web Intelligence' (see Figure 3). The WEBI session launches in a new tab within BI Launchpad or in a separate Internet browser window, depending on how a user's general preferences are set. Once, the blue screen appears, a user can select in the toolbar to build a new report (see Figure 4) or open an existing report from the repository.

Figure 3. Applications

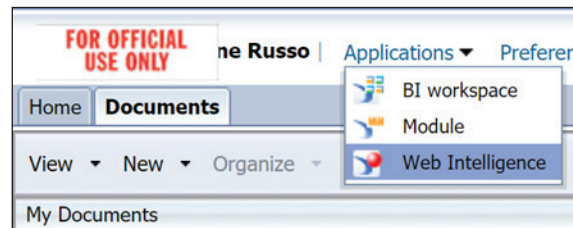
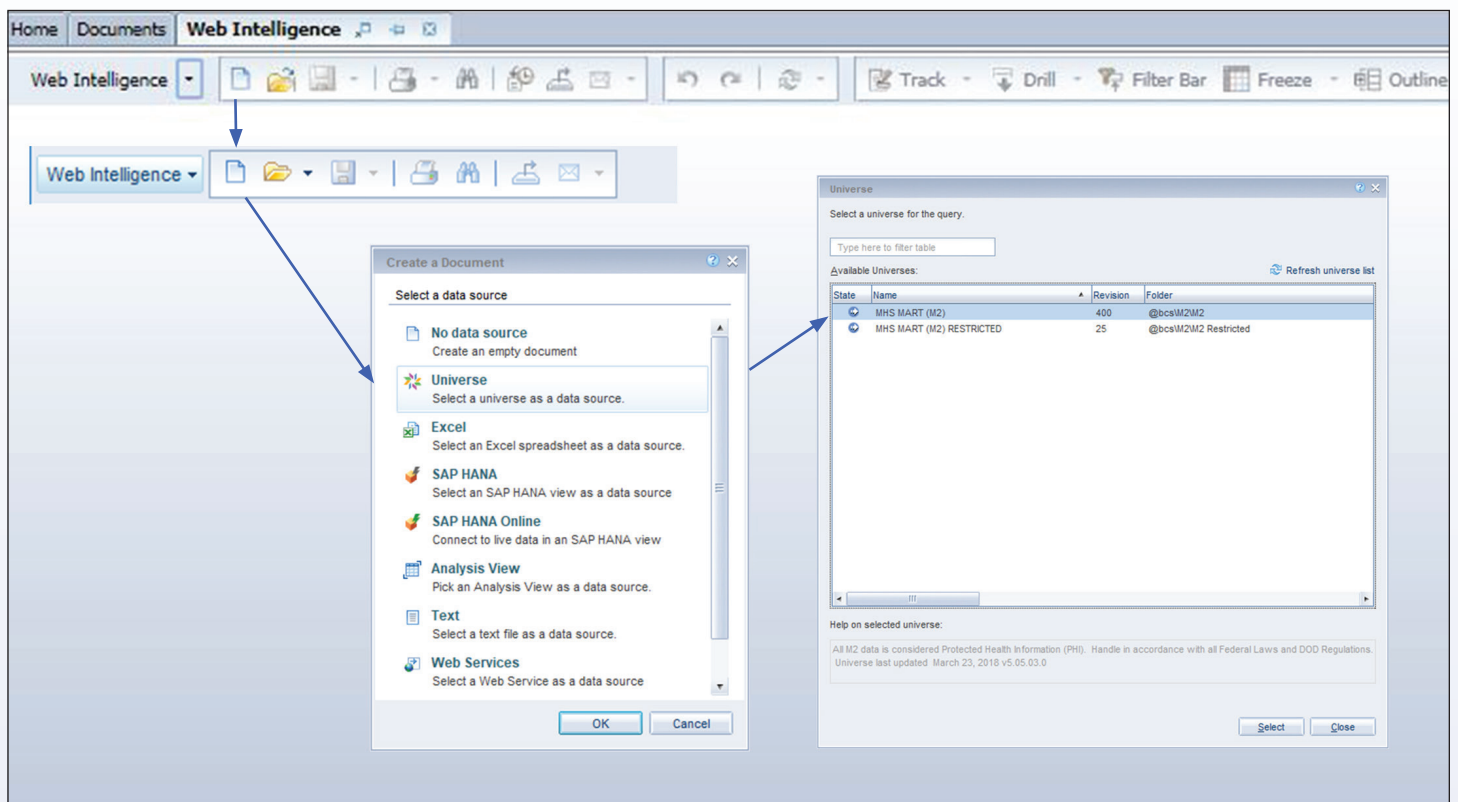


Figure 4. WEBI Session



The first pop-up window asks the user to select the data source. WEBI supports multiple universes and Excel data sources (as long as the Excel file has been uploaded to the BI Launchpad first). If the user selects Universe then he or she is prompted to select which universe. The row limits remain the same, where MHS Mart (M2) is limited to 500,000 rows and MHS Mart (M2) Restricted is set at 10,000 rows.



KNOWLEDGE SOURCES

— UPCOMING CONFERENCES

Below are upcoming conferences for professional growth and development.

April 26-27, 2018:

AcademyHealth's 2018 Health Datapalooza – Washington, DC

<http://www.academyhealth.org/events/site/2018-health-datapalooza>

April 29-May 2, 2018:

15th Annual World Health Care Congress – Washington, DC

<http://www.worldcongress.com/events/HR18000/>

May 14-16, 2018:

VA Healthcare 2018 – Washington, DC

<https://veteransaffairshealthcare.iqpc.com/>

May 21-23, 2018:

WEDI National Conference – Scottsdale, AZ

<https://www.wedi.org/forms/meeting/MeetingFormPublic/view?id=8CD6A000002A8>

June 24-26, 2017:

AcademyHealth 2018 Annual Research Meeting – Seattle, WA

<https://www.academyhealth.org/events/2018-06/2018-annual-research-meeting>

IN THE NEXT ISSUE

The next issue of *Healthcare Analytics in Navy Medicine* will focus on value in health care. The issue will include a discussion of how health care “value” is defined by many organizations. It will also identify many of the value goals targeted by large health systems, including the Military Health System (MHS). How care transformation efforts and value-based targets interact will also be explored.

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